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Contents for this week's MEDNEWS:

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Headline: Guantanamo weathers Hurricane Georges
By LT Karen R. Krull, MSC, U.S. Naval Hospital
Guantanamo Bay

GUANTANAMO BAY, Cuba -- As Hurricane Georges swept through the Caribbean with winds of more than 100 miles per hour, personnel at U.S. Naval Hospital Guantanamo Bay prepared their facility to weather its first hurricane since Hurricane Inez in 1966.

Having the hospital ready for the storm was important for the military and civilian personnel of Guantanamo Bay. The base lies along the southern coastline of Cuba, five miles into Oriente Province. It is completely cut off from Communist Cuba by minefields and a fence line patrolled by Marines.

In a worst case experience with the storm, unless relief was provided from ships, the next nearest help from land-based Naval medical facilities was Miami, about 400 miles to the north or Puerto Rico, abut 600 miles southeast.

"We had over one hundred windows to cover and all of the loose gear on the hospital grounds to secure," said Electrician's Mate First Class Ron Keach, leading petty officer of Operating Management Division. "At first it seemed like an enormous job to accomplish within such a short period of time, but the entire hospital staff really pitched in and got the job done quickly."

Senior leaders at the hospital were aware of the contributions the most junior personnel made preparing for the storm.

“The young troops really pitched in and made it happen. Without their efforts, we would not have been ready in time,” said Senior Chief Hospital Corpsman Wayne White, acting command master chief.

As everyone scurried around readying the facility for the storm, one person observed that hurricanes are more predictable than other examples of nature’s fury. Hospitalman Mindy Konstanz, who works in Patient Administration, said that the storm was quite different from the tornadoes she had seen in her home state of South Dakota. She said, “With hurricanes you get some advance warning, but tornadoes just come out of nowhere.”

The nuts and bolts of preparing for Hurricane Georges started Saturday, September 19. Hospital personnel pre-positioned supplies, prepared disaster control lockers, and they ensured there was enough mass casualty supplies on stand-by. Another step in preparing for the blow was having pre-cut plywood, already numbered to match numbers on the hospital windows, accessible to maintenance parties.

As facilities were prepared, people were not forgotten. Because the base is so isolated, and the Naval Hospital provides the sole medical services to base residents, six pregnant women and four elderly Cuban exiles were brought in to the hospital for safekeeping. In addition to essential medical personnel, the hospital also sheltered eleven of the base’s firefighters.

As the hurricane moved away from Guantanamo Bay, fortunately there were only a few storm-related injuries reported, including a person burned by steam while repairing storm damage at the base desalinization plant.

The storm had also caused minimal facilities damage. Roofs from a few storage sheds were blown off and there were some water leaks in the hospital.

“Due to the amount of foresight used in preparing the hospital, we were able to minimize the amount of damage the hospital received,” said LTJG Melissa Hinesley, Head of Operating Management.

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Headline: Navy Medical team provides lifesaving operation

By JO3 Michelle A. Lewis, Naval Strike and Air Warfare Center

FALLON, Nev. -- Earlier this year, LCDR Michael Tluchowski, and his wife, Michele, did what any concerned parents would do when the older of their two

children, Mallory, began complaining of prolonged headaches: they wasted no time getting her to the family doctor for a checkup.

After several examinations, doctors recommended that Mallory see a pediatric neurologist, and a visit was scheduled for late May. During the days that followed, Mallory's headaches persisted, and the Tluchowskis began noticing a sudden clumsiness in her coordination, especially when she interacted with her younger sister, Madeleine.

Growing more concerned, Tluchowski, a helicopter pilot at the Naval Strike and Air Warfare Center located at Naval Air Station Fallon, Nev., visited senior flight surgeon, LCDR Kris Belland, MC. Belland immediately ordered a Computerized Axial Tomography or CAT scan.

The CAT scan determined that Mallory had a slow-growing, golf ball-sized tumor pressing against the ventricles found at the base of the brain, which was causing headaches. A neurosurgical evaluation was needed to determine the type of tumor.

"Shortly after the diagnosis, as we were beginning to think the impossible, both NSAWC flight surgeons, doctors. Belland and [LCDR Eric] Pagenkopf, stepped in, pulled out the medical books, and for about an hour-and-a-half explained exactly what they thought we were dealing with and the steps we should take," Tluchowski said.

With help from NAS Fallon, Mallory, accompanied by both parents, was on a C-12 aircraft to San Diego for a neurosurgical evaluation in early May, the same day as the CAT scan.

"By 11 o'clock that night, we had landed in San Diego and were on our way to the [San Diego Naval Medical Center]. When we got there, the NSAWC [medical] team had already greased the skids for us," said Tluchowski. "Mallory was admitted and neurologically evaluated."

The evaluation showed that if the tumor was left untreated, it would continue to grow and eventually prove fatal. The surgeons decided to remove it.

Two neurosurgeons, CDR John Grossmith and LCDR Jeffrey Blount, performed the 12-hour operation. Five days after the surgery, the Tluchowskis received final results that confirmed the tumor was non-malignant.

The family stayed in San Diego for ten days of follow-up care before returning to Fallon. But, in less than three months Mallory had to return to Naval Medical Center San Diego for follow-on surgery.

"After the [initial] surgery, there was a little leak in the dura, which is the brain lining," Belland said. "This caused a bump the size of a tennis ball at the back of Mallory's head.

According to Belland, the leak and a suspected

residual tumor prompted the decision to go back in several weeks later, fix the dura and at the same time, get what was believed to be a residual tumor. During the seven-hour operation, the dura was sealed, and what turned out to be residual tissue and not a tumor was removed.

“She couldn’t be doing better,” Belland said. “She’s about 98 percent back to the way she was before the tumor. The remaining two percent will come in time.”

The entire experience, according to Michele, makes her proud that she’s part of the Navy family: “NSAWC, and the Navy in general, have been just wonderful. They got our family through a time we thought was impossible to get through….”

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Headline: Readiness model ensures right people provide medical support

By Earl W. Hicks, Bureau of Medicine and Surgery

WASHINGTON -- Navy Medicine has a direct impact on the readiness of Navy and Marine Corps units. Whether they are forward deployed or providing support roles in the continental United States, Sailors and Marines need medical support. The Navy Medical Department is a formidable care-providing organization of corpsmen, doctors, nurses, researchers and administrators meeting that need.

Just as the Fleet has a plan to staff and maneuver ships, Navy Medicine has a plan to keep the fighting forces contributing to readiness. To carry out this plan, Navy Medicine uses a management model called Total Healthcare Support Readiness Requirements (THCSRR). It answers the question of how many Continental United States facilities are necessary to support Navy Medicine’s readiness requirement. This model ensures the Navy Medical team has the right person, with the right training and equipment, in the right place, at the right time to care for Sailors, Marines, their families and all others entrusted to Navy Medical care.

It is a simple concept that makes the system work: Navy Medicine exists to support the Fleet and Fleet Marine Forces. To provide that readiness support, Navy Medical teams are assigned to operational platforms such as hospital ships, Fleet hospitals, Marine units, and Casualty Receiving Treatment Ships, among other readiness assignments. Those vessels and locations are considered their primary readiness platform.

According to CAPT Penny Turner, NC, Director, Readiness Reengineering Task Force at the Bureau of Medicine and Surgery, “The reason we have a direct

care system is to support readiness. Our military treatment facilities really serve two purposes, to staff operational platforms when required and to provide high quality, low cost health care."

In between deployments, the medical team is assigned to military treatment facilities, such as medical centers, hospitals, clinics and ambulatory care centers. The facility is responsible for providing personnel to its assigned platform in times of deployment. For example, Naval Hospital Bremerton, Wash., would provide support to Fleet Hospital Bremerton. Therefore, when Fleet Hospital Bremerton is needed, the 978 professionals of Naval Hospital Bremerton, who have trained and worked together on a daily basis, staff the Fleet Hospital. Naval Medical Center Bethesda, Md., a much larger facility than the hospital at Bremerton, has a larger crisis deployment requirement and supports USNS Comfort (T-AH 20), two Casualty Receiving Treatment Ships, Fleet Marine Force units and overseas facilities augmentation.

Something else evolves from this staffing model: the total force concept. This means Reserve forces are deployed to Military Treatment Facilities when the active duty staff deploys to the readiness platform. To ensure the model is working correctly, frequent "test" operational deployments are held throughout the year, moving certain military treatment facility personnel to their primary operational platforms. National Naval Medical Center Bethesda personnel deployed in July to their operational platform, USNS Comfort (T-AH 20), which supported Operation Baltic Challenge '98. Reserve unit 106 attached to the medical center, and Reserve unit 119 from San Diego, among others, already designated to support the medical center, came in and assumed care-giving and administrative responsibilities. The whole test process is evaluated and graded to identify weaknesses and correct them before a real emergency or wartime deployment.

Their assignments between deployments and maintenance of the facilities help the medical team accomplish a number of goals: hospitals maintain a bed count in case of a crisis, and operational medical forces are provided a rotation source. Working in the medical facilities also helps medical personnel maintain professional readiness skills, and it helps maintain high quality care for all who receive their care at a military treatment facility such as active duty, retirees, and eligible family members.

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Headline: Opticians, therapists enhance medical care at sea

By HMCM(SW) Michael C. Carr, U.S. Naval Hospital

Okinawa

OKINAWA, Japan -- To ensure that Sailors can see at sea and that they are working in a safe environment, U.S. Naval Hospital Okinawa recently sent members of the optometry, occupational and physical therapy departments to the USS Germantown (LSD 42) for 16 days of a recent deployment.

LT Theresa Frith, MSC, and Hospital Corpsman Third Class Paul Schultz, conducted ship's crew eye exams and provided training to the medical staff on board the Sasebo, Japan-based ship.

The optical staff was joined on the ship by LCDR Nancy Brown, MSC, a physical therapist and LTJG Shanna Howe, MSC, an occupational therapist, who evaluated ergonomic considerations aboard the ship that affected the safety and readiness of the crew.

Both groups of medical professionals wasted no time after the ship got underway. They coordinated with the ship's medical team to accomplish as much as possible during their brief stay.

Frith and Schultz completed more than 140 visual exams for Sailors and Marines, raising the crew's C-1 readiness status for eye exams to 100 percent. More than 300 orders for spectacles and gas mask inserts were also initiated.

In addition to the 18 hours of in-service training given to the medical staff, Schultz also completed repairs on the ship's Armed Forces Vision Tester machine. The Germantown's medical staff are now fully trained in fitting, measuring, and ordering the Navy's Frames-of-Choice spectacles.

Meanwhile, Brown and Howe were busy providing physical and occupational therapy evaluations of Sailors and Marines. They also evaluated the ship's ergonomic risk factors. Part of their work also included providing training sessions to the ship's Hospital Corpsmen on basic wound healing, management of acute burns, and proper splinting for tendon repairs, among other topics.

For U.S. Naval Hospital Okinawa, it was another example of taking health care to the deckplates. For the Germantown crew, it was an opportunity to receive additional medical support without being alongside its homeport pier.

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Headline: Camp Lejeune Sailors help Haitian community
By Sgt. John Barwell, USMC, 2nd Medical Battalion

Port au Prince, Haiti -- Although the main mission of the 55 Sailors and Marines of the 2d Medical Battalion Medical Task Force, deployed to Haiti from Camp Lejeune, N.C., is to maintain the U.S. Support

Group’s field hospital and provide care to the hundreds of U.S. and U.N. servicemembers stationed there, most of their work stems from helping the community.

Since their July arrival, these corpsmen, doctors and nurses have treated more than 6,000 Haitian patients during numerous humanitarian assistance missions within Port au Prince. From simple cuts and broken bones, to gangrenous wounds and untreated first-degree burns -- you name it, these folks see it and treat it, nearly every day.

During a recent visit to Mother Teresa’s Missionary Brothers of Charity School, one of many sites the team visits on a weekly basis, about 30 corpsmen, doctors and nurses tended to 512 Haitian patients in only three hours. During the afternoon, hundreds of wounds were cleaned and bandaged, dozens of cysts were removed and more than 800 prescriptions were filled.

“It’s very depressing here,” said Hospital Corpsman First Class James M. Miller of Long Beach, Miss. “I never could have imagined the extent of [the Haitians’] anguish and suffering.”

Widespread poverty and few medical resources make seeking the simplest of treatments a nearly impossible task for the vast majority of people here. These site visits are the only means of reliable medical aid for the thousands of Haitians who live within the poorer sections of Port au Prince.

In Haiti, every injury is potentially deadly. For the people who live in the filthy, disease-stricken slums, an everyday cut can quickly fester into a life- or limb-threatening condition.

Although the environment is dreary, the training for the Navy detachment is invaluable. “We just don’t see this stuff in the states,” said Hospital Corpsman Third Class Stacey L. Baker of Greenlake, Wis. “This is stuff you only read about in books.”

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Headline: Jacksonville tests newborns for hearing problems

By Terresa D. White, Naval Hospital Jacksonville

JACKSONVILLE, Fla. -- Care for newborn patients at Naval Hospital Jacksonville got better in early September when all babies born at the naval hospital began receiving a simple, 10-minute hearing exam.

“Newborn hearing loss is the most common birth defect, with approximately three children in 1,000 affected by some degree of impairment,” said LCDR Tim Dunlevy, MC, an ear, nose and throat specialist who led the program.

Surprisingly, most children are not diagnosed with hearing loss until they are two or older. Milder

losses are sometimes not recognized until a child enters school. These first critical years when a child is learning to speak have proven to be irrecoverable. Studies show that a child with an undiagnosed hearing impairment may never catch up with other children in speaking ability.

"Detecting infant hearing problems is harder than you might think," Dunlevy explained. "Often children react to loud noises, but cannot hear a conversation. Or, parents may mistake reactions to movements or facial expressions as proof of hearing. Fortunately, this procedure will allow us to identify babies [with hearing problems] before they leave the hospital, so they can receive prompt assistance."

The test itself is simple, painless and takes place while the baby is sleeping. A small plastic probe about the size of a pencil eraser is placed in the baby's ear. The probe emits a series of soft clicks while a microphone in the probe measures the vibrations the inner ear makes in response.

The test is extremely accurate and is conducted by trained technicians on the maternal/infant ward. If the baby fails the test, he or she will be retested within 24 hours. A second failure results in a referral to Nemours Children's Clinic in downtown Jacksonville, where even more accurate testing is done.

If it turns out that there is some degree of hearing loss, doctors at Nemours will consult with the family about the best course of action. In many cases, a baby as young as three months can be fitted with a hearing aid. With early identification and early intervention, children generally develop at a normal rate.

"Often a hearing aid is all it takes to give a child normal hearing," Dunlevy said.
Nurses on the maternal/infant ward have a 12-minute videotape about the hearing test available for new parents.

"Universal newborn hearing screening is widely recognized as essential for early intervention," said Dunlevy. "Currently, seven states have passed laws requiring the tests and there is legislation pending in several others. We at Naval Hospital Jacksonville care about the health and well being of our patients and felt this was an important service that we should be offering. If we can help just one child, it will be well worth the effort."

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Headline: TRICARE question and answer

Question: How does the health care I receive under TRICARE get paid for?

Answer: When you receive health care under TRICARE, somebody has to pay for it. If the government is going to pay its share of the cost of covered care, somebody has to send a claim in to the proper TRICARE contractor. It may be you or it may be the doctor or hospital. But somebody has to send in a claim, or Uncle Sam won't know you got the care--and won't pay any of the costs.

If you're enrolled in TRICARE Prime, or are using TRICARE Extra, and are being treated by a TRICARE network provider of care, the provider will always file claims for you. If you get care under TRICARE Standard, your provider may or may not file claims for you.

Before you get medical care from a civilian source with TRICARE Standard, talk to the provider of care or his/her staff, to determine who's going to file the claim with the TRICARE contractor. If they do it, they'll have their own forms to use (the HCFA 1500 for individual providers or the UB-92 for hospitals and other institutional providers). If you file the claim, you'll need DD Form 2642 ("CHAMPUS Claim: Patient's Request for Medical Payment").

If you have to file a claim yourself, you can get the DD Form 2642 at TRICARE service centers or from health benefits advisers at military medical facilities. If you can't get claim forms from these sources, write to the TRICARE Management Activity, 16401 E. Centretech Parkway, Aurora, Col., 80011-9043.

If you have Internet access, you can also get the claim form on-line. Just go to the Military Health System's home page, at: www.ha.osd.mil; or: www.tso.osd.mil.

When you file a claim, don't send just the bills in. They have to be attached to a claim form. Fill out the claim form completely and accurately (it's only a half-page long) and sign it--then attach copies of the itemized bills to the claim and send it in to your regional TRICARE contractor. You have one year from the date you received the service, or one year from your date of discharge from an inpatient facility to get the claim to the contractor for processing.

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Headline: Healthwatch: Military moms speak out on breast cancer
By LT Richard Haupt, USN, TRICARE Southern California Region

SAN DIEGO -- The last thing Air Force Technical Sergeant Melynn Reid and Navy Petty Officer Marsha Craten were thinking of when they were diagnosed with breast cancer was publicity. But following their recovery, they’ve found themselves in a very visible

leadership role in the Department of Defense's Breast Cancer Prevention, Diagnosis and Education Program, a department-wide disease management program administered through TRICARE, the military health care plan.

Reid and Craten, who've been featured on local television news programs and a nationwide poster campaign, spoke September 15 to attendees at DOD's 1998 Breast Cancer Conference here.

"When I was first diagnosed, I couldn't believe it was happening to me," said Reid. "I had always been active and healthy. I really focused on getting well and not letting the experience get me down."

Reid, 35, an aircraft technician now assigned to Edwards AFB, Calif., was diagnosed with breast cancer June 1997 while serving at Kadena AB in Okinawa, Japan. Seven days later, she was medically evacuated to Naval Medical Center San Diego where she underwent surgery. She began chemotherapy in July and radiation therapy in November.

"The hardest day came following my recovery when I put my wig away," said Reid. "My hair had changed color when it came back in. I felt as though my identity had changed. It was really hard, but getting rid of the wig allowed me to shed the last part of being sick."

Craten, 37, a supply clerk first class at Space and Naval Warfare Command in San Diego was diagnosed with breast cancer in December 1996. In January 1997, she found out she was pregnant. She underwent surgery during the sixth week of her pregnancy to remove the cancerous cells. Following the delivery of a healthy and happy baby daughter in September, she underwent eight weeks of radiation therapy.

"The cancer was a shock, but dealing with the pregnancy caused for some difficult decisions," said Craten. "I decided to have surgery during my pregnancy, knowing that I would be at higher risk for a miscarriage. It was a tough decision, but everything came out good and I don't regret it."

Although both are very modest women, Reid and Craten have enjoyed being on the forefront of TRICARE's program.

"My experience made me reach out to others," said Craten. "For everything this hospital (Naval Medical Center San Diego) has done for me, sharing my story is the least I could do."

"If I can help one person by telling my story, it will be well worth it," said Reid. "I'm proud to be associated with the TRICARE breast cancer program."

Disease management is an integral component of the managed care approach to medicine. TRICARE Southern California's breast cancer program relies on clinical screening exams by primary care managers, mammograms,

extensive patient education and patient self-exams.

"Disease Management is a comprehensive approach to care which focuses on the natural course of a particular disease process," said Navy Capt. Barry Cohen, MC, head of clinical operations for TRICARE Southern California, Region Nine. "It targets populations who either currently have a particular disease, or who are at high risk for developing it by emphasizing strategies for disease prevention and maintaining wellness in those already afflicted."

In 1997, Cohen's office established Breast Education Centers at outlying military treatment facilities in southern California and a Breast Health Center at Naval Medical Center San Diego. The education centers, each staffed with a registered nurse, are tasked with educating women and spouses on the latest facts related to the prevention and early diagnosis of the disease, and refer patients as needed to the Breast Health Center in San Diego.

The Breast Health Center, staffed by a psychologist, physical therapist, dietician, social worker, along with various doctors and nurses, is a comprehensive clinic for all types of breast disease..

Reid, whose husband is also on active duty in the Air Force, was selected for promotion to Master Sergeant in June and is expecting to deliver their fifth child in January.

"I'm blessed with a good career and wonderful husband and family," she said. "We weren't expecting to have another child, but had I not overcome the disease, it would have never even been possible. I'm very thankful to be here today."

Breast Care Facts
National
*One in eight women develop breast cancer over a lifetime
*Breast cancer is the leading cause of death in women ages 15-54
*Most common cancer in American women
*Every woman is at risk for breast cancer
Department of Defense
*Congress funded $25M for the DoD Breast Cancer Prevention, Diagnosis and Education Initiative in FY 96, 97 & 98, because:
*Women comprise 35% of the Military Health System (MHS) beneficiaries
*Women represent 13% of the active-duty military force
*Nearly 18,000 new cases of breast cancer are diagnosed in the MHS annually
*Direct readiness issue for active-duty women; indirect readiness issue for active-duty dependent women; emotional, painful, emotional and costly

treatment for all
*Breast Care Initiative executed through TRICARE as an integral part of preventive medicine, a feature of the managed care approach to healthcare

TRICARE Southern California
*TRICARE Southern California Breast Care Initiative initially funded at $2.5M
*Breast Health Center at Naval Medical Center San Diego opened in April, 1997
*Available by referral to all military beneficiaries in southern California
*Staffed with psychologist, physical therapist, dietician, social worker and nurses
*Consulting specialists from cancer center (oncology, pathology, radiology)
*Breast Care Educational Centers at seven military treatment facilities in the region: Camp Pendleton, Edwards AFB, Fort Irwin, Los Angeles AFB, Port Hueneme, Twentynine Palms, Vandenberg AFB
*Focus on promoting early detection, awareness and prevention
*Staffed by an RN
*Educate young active-duty women, dependents and spouses on latest facts, breast self-exam, breast care, diet and exercise
*Offer support groups and public speaking

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Comments about and ideas for MEDNEWS are welcome. Story submissions are encouraged. Contact MEDNEWS editor, Earl Hicks, at email: mednews@us.med.navy.mil; Telephone 202/762-3223, (DSN) 762-3223, or fax 202/762-3224.

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